STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State North Carolina

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Definition of claim:

a. Pharmacy claim – a single prescription (line item of service) for an individual recipient within a bill.

b. All other non-institutional provider claims – a bill for services for one recipient. All services furnished to a patient over a period of time may be submitted on a single bill and is one claim.

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State/Territory: North Carolina

Requirements for Third Party Liability –
Identifying Liable Resources

1. All data exchanges will be conducted as required by 433.138 (d)(1), (d)(3), and (d)(4) as follows:

   a. SWICA and SSA application and redetermination and "batch" run with a printout at least quarterly.

   b. IRS match at application and at least annually.

   c. Unemployment compensation on line at application and redetermination and "batch" run with printouts at least quarterly.

   d. Motor vehicle data matches cannot be done in North Carolina at this time. Required data elements are not available for matching from DMV. See Attachments 1 and 2 of the North Carolina TPL action plan for the documentation on attempted matching.

      Worker's compensation data matches have not been done at this time. Discussions are underway for this process. We are targeting December 31, 1991 for a completion date.

   e. The Title IV-A agency is a sister agency to Medicaid under the Department of Human Resources and information is shared at application and redetermination time. Information from the applicant/recipient is required to be furnished to the IV-D agency on the absent parent, including SSN, health insurance information, workman's compensation, and unemployment insurance. This information is placed in the case record. IV-D furnishes information on support/court orders for absent and custodial parents and is followed up by the TPL Unit. Data matches with IV-D cannot be accomplished at this time. However, the TPL data base is being modified in order that this can be accomplished. Target date for matching is January 1992. The DEERS match cannot be accomplished until the IV-D interface is made. However, after the accomplishment of the IV-D data match, the DEERS match will be accomplished.

      As provided by 433.138(c), trauma claims are identified by the FA and a monthly report is produced by the FA using the required trauma code edits.

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2. The methods used for follow-up as required by 433.138 (g)(1)(i) and (g)(2)(i) are:

   a. The eligibility worker verifies all information, including potential TPL, within thirty (30) days and the TPL information is incorporated into the eligibility case file, the TPL data base and the third party recovery unit.

   b. Worker's compensation data will be verified and TPL information will be incorporated into the eligibility case file, the TPL data base and the third party recovery unit within thirty (30) days.

   c. If follow-ups are necessary for 2a or 2b, they will be done by correspondence and/or telephone within sixty (60) days.

3. The Department of Motor Vehicle data is unavailable. See Attachments 1 and 2 of the North Carolina TPL action plan for documentation.

4. All claims paid for a given recipient with an ICD9-CM diagnosis code between 800.00 and 999.99 are accumulated for one month and a system generated inquiry is mailed to the recipient requesting information regarding the possible accident. Information received from the recipient regarding potential TPL is incorporated into the TPL case file within thirty (30) days. Claims are then filed with the potential third party carrier or recipient attorney.

   The third party recovery unit will keep records of trauma diagnosis code recoveries and will, at least annually, identify those diagnosis codes that produce the greatest amount of recovery and give those codes priority for follow-up.

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(1) The provider must indicate, in writing, either on the hardcopy claim form or a separate form that he had billed the third party and has not received payment. The TPL unit will verify with the insurance carrier the availability of third party payments and if the payments are available, the TPL unit will bill the third party for reimbursement to the Medicaid program. If the absent or custodial parent is to make medical support payments, in cash, through the clerk of courts office, the TPL unit will bill the absent or custodial parent for medical services on a routine schedule, not to exceed every sixty (60) days if there has been Medicaid payments on behalf of the child(ren). For those absent parents who are court ordered to provide health insurance, the TPL unit will pay and chase the Medicaid claims. If the provider uses electronic billing, the TPL unit will do selective monitoring to verify provider compliance with this regulation. This will be done by selecting a sample of recipients with TPL available and securing the paid claim history for the proceeding three (3) months for these recipients and verify with the third party carrier the information the provider furnished on his claim form.

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(2) The State of North Carolina will pay and chase those claims for prenatal and preventive pediatric services including EPSDT for those recipients that have major medical insurance coverage. The TPL unit will accumulate these claims for a period of six (6) months and bill the major medical carriers for payment. The first billing will be done in January, 1992 for claims paid May 7, 1991 to December 31, 1991. After that, they will be billed to the insurance carrier each July and January for the preceding six (6) months.

(3) North Carolina does not use a threshold for TPL claims processing. We cost avoid all claims, except those for which we have a waiver, when there is health insurance indicated on the TPL data base and recipient eligibility file.

(4) All claims for a recipient related to trauma diagnosis code between 800.00 and 999.99 are accumulated for a period of one (1) month and a questionnaire is mailed to that recipient at the end of the month requesting information related to a possible accident and any and all information regarding the liable party and/or the recipient’s attorney. See Attachment 3 in the North Carolina TPL Action Plan for a sample copy of the questionnaire.

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(5) North Carolina has a waiver to pay and chase pharmacy claims. We accumulate these claims for a period of six (6) months and bill the respective insurance carrier. Each of our semiannual collections, to date has exceeded $500,000. Our cost to benefit ratio to cost avoid pharmacy claims is 1:8. Our cost benefit ratio to pay and chase pharmacy claims is 1:11.6.

Citation | Conditions or Requirement

1906 of the Act — State Method on Cost Effectiveness of Employer-Based Group Health Plans

I. The State of North Carolina uses the following methods to determine the cost effectiveness of paying group health insurance premiums for Medicaid clients:

1 - Cost Effectiveness Based on Client Diagnosis:

The determination of cost effectiveness is based on the comparison of premium amounts and the policyholder obligations against the anticipated expenditures identified with a diagnosis that will require long term treatment. Such a diagnosis would include cancer, chronic heart disease, congenital heart disease, end stage renal disease and AIDS. This list will be expanded as diagnoses associated with anticipated long term care are targeted. This method of determination is also appropriate for short term high expense treatments such as a pregnancy. A client's case is considered as cost effective when anticipated expenditures associated with the diagnosis exceed the premium amounts and policyholder obligations as the condition is likely to continue.

2 - Cost Effectiveness Based on Actual Expenditures:

The determination of cost effectiveness is based on the comparison of premium amounts and policy holder obligations against the actual claims experience for the client. Documentation of actual expenditures consists of Explanation of Benefits (EOB's) from the client's health carrier for previous charges or Medicaid expenditures for previous periods of the client's eligibility. A client's case is determined as cost effective if actual claim expenditures exceed premium amounts and policyholder obligations.

3 - Cost Effectiveness Based on Expenditure Projections:

The determination of cost effectiveness is based on the comparison of the amount of the annual premium, deductibles, coinsurance, policyholder cost sharing obligations and additional administrative cost against the average annual cost of Medicaid expenditures for the recipient's eligibility classification for types of service covered under a group plan. The Medicaid Management Information System (MMIS) is utilized to obtain the average annual Medicaid cost of a recipient by age, sex, qualifying category and geographical location. A client's case is determined as cost effective if the amount of the premium, deductibles, coinsurance, cost sharing obligations and administrative cost are less than the Medicaid expenditures for an equivalent set of services.

II. Because Federal Financial Participation (FFP) is available for the payment of premiums for Medicaid recipients enrolled in a cost effective group health plan:

1 - Medicaid will pay the health insurance premiums (policyholder portion only if an employment related policy) for Medicaid recipients with policies likely to be cost effective to the Medicaid Program. Payments shall be made directly to the insurer providing the coverage, the employer or to the Medicaid recipient or guardian.

2 - Medicaid will pay the Medicaid allowable amount for all items and services provided the Medicaid recipient under the state plan that are not covered under the group health plan.

3 - Medicaid will provide for the payment of premiums when cost effective for non-Medicaid eligible family members in order to enroll a Medicaid eligible family member in the group health plan.

4 - Medicaid will treat the group health plan as a third party resource in accordance with North Carolina Medicaid TPL cost avoidance policies.

5 - The health carrier, employer, recipient or non-Medicaid eligible family member will immediately notify this agency of any event that might affect the policyholder status or the cost effectiveness of the health insurance policy.

6 - The North Carolina Medicaid program will receive referrals for potential candidates for the payment of premiums.

State/Territory: North Carolina

Citation		Sanctions for Psychiatric Hospitals
1902 (y) (1), 1902(y)(2)A, and Section 1902 (y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)	(a)	The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b)	The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c)	When the State determines that the hospital does not met the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan: or 2. Provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d)	When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: North Carolina

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below: (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management on a case by case basis: (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e). ____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

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INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES

Match With	General Description and Frequency
North Carolina Employment Security Commission (ESC)	on-line inquiry available to be used at applications and redeterminations for wages reported by employers and unemployment insurance benefits. quarterly paper print of ESC wage information and UI benefits.
Social Security Administration (SSA)	on-line and monthly printout of BENDEX information for SSA benefits. on-line and monthly printout on SDX for SSI benefits and other income shown by SSA. monthly match with Beneficiary Earnings Exchange Report (BEER) to identify clients with earnings reported to SSA. validate SSN’s of recipients with NUMIDENT file as soon as SSN is in system and if any vital data changes in system
Internal Revenue Service (IRS)	annual match of complete recipient file and monthly match of approved applicants to get 1099 unearned income data.
North Carolina Department of Transportation (DOT)	on-line inquiry of motor vehicle ownership to be used at redeterminations and applications.

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METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

The Medicaid identification card for an eligible individual who can give no mailing address is sent to the address of the local department of social services in the county where the individual applied. The individual is instructed at the time of his application and at each subsequent redetermination to go to the county agency on the first work day of each month to pick up his ID card for that month.

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REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

See Supplements:

Supplement 1: North Carolina state summary of law concerning patients' rights. Pamphlet is titled "Medical Care Decisions and Advance Directives – What you Should Know."

Supplement 2: Detailed information on North Carolina's living will (Declaration of a Desire for a Natural Death), health care power of attorney and mental health advance directive (Advance Instruction for Mental Health Treatment).

State law does not explicitly allow a provider to object to implementation of advance directives on the basis of conscience.